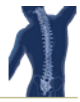
PIONEER SCOLIOSIS REHABILITATION 

Patient Intake Form

Patient Name: _____DOB: _____ Age: _____
Address: _____
Phone: Home: _____ Cell: _____Work: _____
Emergency Contact: _____
Email: _____

SCOLIOSIS HISTORY
Family History of Scoliosis ☐Y ☐N ☐Parents ☐Siblings ☐Children ☐_____
Age at initial diagnosis: _____
Curve Type /Degree: _____
Most Recent X-ray or MRI & Result: _____
_____
Other associated diagnosis with scoliosis: _____
Do you currently have a doctor who monitors your scoliosis: ☐Y ☐N
Problems related to your scoliosis: Pain ☐Y ☐N
If yes, describe location of pain: _____
Respiratory Problems ☐Y ☐N
Concerns about your posture ☐Y ☐N ☐Other, describe
_____
Do you exercise regularly? ☐Y ☐N
If yes, describe type of exercise and frequency: _____
MEDICAL / SURGICAL HISTORY_____
_____
_____
☐Arthritis/ Osteoporosis ☐Back Pain ☐Balance Problems ☐Diabetes
☐Depression/ Anxiety ☐Disturbed Sleep ☐Dizziness/ Headaches ☐Fatigue
☐Heart Problem ☐High Blood Pressure ☐High Cholesterol ☐Previous Fractures
☐Respiratory Problems ☐Seizures ☐Stroke ☐Swelling ☐Other
_____
Allergies: ☐Latex ☐Other _____
MEDICATIONS, please list: _____
_____
_____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Pioneer Scoliosis Rehabilitation, 15 Conz Street, Northampton, MA 01060
Phone: (413) 230-7644 | Fax: (413) 523-0264